



SELECT COMMITTEE ON AUTOMOBILE INSURANCE/PIP REFORM

JD Alexander, Chair
Lesley "Les" Miller, Jr., Vice Chair

Meeting Packet

Monday, March 3, 2003
2:00 p.m. – 4:00 p.m.
Room 37, Senate Office Building

***(Please bring this packet to the committee meeting.
Duplicate materials will not be available.)***

A G E N D A

SELECT COMMITTEE ON AUTOMOBILE INSURANCE/PIP REFORM

Senator JD Alexander, CHAIR

Senator Lesley "Les" Miller, Jr., VICE-CHAIR

DATE: Monday, March 3, 2003

TIME: 2:00 p.m. -- 4:00 p.m.

PLACE: Room 37 (LL), Senate Office Building

MEMBERS: Senator Aronberg
Senator Atwater
Senator Garcia
Senator Geller

Senator Posey
Senator Sebesta
Senator Siplin

TAB	BILL NO. AND INTRODUCER	BILL DESCRIPTION AND SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
<hr/> Consideration of proposed final report and recommendations relating to Automobile Insurance/PIP Reform <hr/>			



THE FLORIDA SENATE
SELECT COMMITTEE ON
AUTOMOBILE INSURANCE / PIP REFORM

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March 3, 2003

The Honorable James E. "Jim" King, Jr.
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, FL 32399-1100

Dear Mr. President:

I am pleased to transmit this letter to you which contains the report and recommendations of the Select Committee on Automobile Insurance/PIP Reform. On December 5, 2002, you appointed the Select Committee to address the problems with Personal Injury Protection insurance which range from fraud and abuse to the soaring costs that exist within this automobile insurance market. The Select Committee has taken great care to follow your charge and seek input from the various stakeholders involved.

The Select Committee on Automobile Insurance/PIP Reform met five times during January and February. At the first four meetings the committee heard testimony and information from the interested parties, the Department of Financial Services and the Department of Health. We obtained written input before, during and after our meetings and received testimony from a wide variety of interests: insurance companies, trial lawyers, fraud investigators, medical consultants, agency regulators, and representatives from the hospital, chiropractic, medical, trial, and insurance associations. We received many written proposals for statutory changes and funding increases.

In the testimony we received, there was a consensus that the Legislature accomplished important reforms with the passage of automobile insurance legislation in both the 1998 and 2001 Sessions (ch. 98-270; ch. 2001-271; and, ch. 2001-163, L.O.F.). Those reforms included:

- Requiring providers to submit statements and bills for medical services in a timely fashion on specified forms with procedural codes;
- Revising geographical requirements for independent medical examinations (IMEs) of claimants;

JAMES E. "JIM" KING, JR.
President

ALEX DIAZ DE LA PORTILLA
President Pro Tempore

- Requiring health care clinics to register with the Department of Health and have a licensed physician as medical director;
- Adopting a medical fee schedule for specified procedures;
- Curtailing the activities of “brokers,” who improperly received compensation from insurers or insureds for the use of medical equipment. The improper activities of brokers were defined and charges for services rendered by such persons were made noncompensable and unenforceable;
- Requiring, as a condition precedent to filing actions for non-payment of PIP claims, that insurers receive a 7 day notice of the intent to litigate via a “demand letter;”
- Elevating the ranking of specific insurance fraud crimes under the Offense Severity Ranking Chart law and increasing penalties for other insurance related crimes;
- Limiting access to vehicle accident (crash) reports so that illegal solicitation activity could be curtailed; and,
- Creating a civil cause of action to allow insurers to sue a person who, in connection with a PIP claim, is found guilty of, or plead guilty or nolo contendere (regardless of adjudication of guilt) to, insurance fraud, patient brokering, or kickbacks.

However, members agreed that the above reforms did not go far enough in attacking the problems of fraud and abuse occurring within the PIP system. There was also a consensus among the members that the goals behind the Legislature’s adoption of the PIP no-fault law in 1971 (ch. 71-252, L.O.F.) have been significantly compromised. Those goals were to replace the existing tort system as a means to quickly and efficiently compensate an accident victim regardless of fault, reduce the volume of lawsuits by eliminating minor injuries from the tort system, provide a better distribution of the insurance premium dollar, and reduce overall motor vehicle insurance costs.

After hearing the testimony, there was general agreement among the members of the Select Committee that:

- Fraud continues to permeate the PIP insurance market and constitutes a serious problem in Florida.
- According to the Division of Insurance Fraud, fraud adds as much as \$240 to the average Florida family’s auto insurance premiums, annually.

- Over the past 5 years, the average Florida PIP claim rose 33 percent (from \$4,287 to \$5,687), and PIP and BI (bodily injury liability) loss costs (amount of premium needed per insured vehicle to pay claims) have escalated by 35 percent and 18 percent, respectively;
- As costs escalate, as many as 22 percent of Florida drivers choose not to carry PIP insurance, according to the Department of Highway Safety and Motor Vehicles.
- Florida is the 4th highest in terms of both PIP and BI loss costs among the 13 states which have no-fault (PIP) laws.
- Florida's PIP coverage benefit of \$10,000 has not kept up with inflation and is worth \$3,730 in today's dollars based on the Consumer Price Index. Of the other no-fault states, six states provide higher PIP coverage benefits than Florida, two states offer the same coverage, and four states require less coverage benefits than Florida.
- Florida's verbal threshold, which allows persons injured in motor vehicle accidents to sue for non-economic damages (pain and suffering), is considered "weak," as compared with the other four states which have verbal thresholds, particularly Michigan, New York and Pennsylvania.
- Medically inappropriate diagnostic testing, inflated charges, and over-utilization of treatments by certain medical providers greatly impact PIP and BI insurance costs.
- In certain cases, both insurers and providers are improperly and systematically changing codes which apply to the provision of medical services. Furthermore, in some instances, insurance companies improperly request physicians preparing independent medical examination (IMEs) reports to change or modify the report.
- According to representatives with the Department of Health, 2,404 health care clinics are currently registered with the Department, however, the agency lacks the statutory authority or the necessary resources to perform adequate background investigations of clinic owners or to investigate and inspect clinics.
- Many PIP disputes are litigated due to the cumulative impact of the following statutory and case law provisions which encourage lawsuits on the part of plaintiffs against insurers: one-way attorney's fees statute (allows only insured or medical provider to be awarded attorney's fees if they prevail, but not insurers), Lodestar and contingency risk multipliers (case law created provisions which can increase plaintiff's attorney's fees),

civil remedy and punitive damage provisions which may be utilized against insurers, plus payment of interest and costs to the prevailing party.

The Select Committee on Automobile Insurance/PIP Reform makes the following recommendations:

Automobile Insurance Fraud

The Select Committee heard testimony from representatives with the Division of Insurance Fraud who stated that the vast majority of PIP fraud involves solicitation of accident victims and staged accidents. Organized fraud rings use “runners” to obtain accident reports from law enforcement agencies and then solicit persons involved in these accidents on behalf of unscrupulous attorneys and doctors. Once recruited, the accident victim is sent to an attorney who refers the person to a medical provider or clinic where he or she receives a battery of unnecessary tests. According to the Division of Insurance Fraud, most of these tests are highly profitable, but of little or no use or validity. These tests often exhaust the insured’s \$10,000 PIP coverage benefit and position the attorney to improperly sue the insurer. Other rings “stage” vehicular accidents in order to defraud the PIP system.

The Select Committee believes that the Legislature should consider enacting reforms to combat fraud, enhance penalties for those found guilty of “milking” the automobile insurance system, and provide investigative resources to the Division of Insurance Fraud within the Department of Financial Services. Specifically, we recommend:

- **Solicitation of Accident Victims:**
 - Provide that solicitation, for the purpose of making a PIP claim with “intent to defraud,” is a second-degree felony (increased from third-degree).
 - Provide that any solicitation, for the purpose of making a PIP claim within 60 days of a vehicle accident (except for advertising), is a third-degree felony.
 - Provide that any solicitation, for the purpose of making a PIP claim more than 60 days after an accident, by specified professionals (lawyers, chiropractors, medical providers, or owners or medical directors of clinics), at the victim’s residence in person or by telephone contact, is a third-degree felony.
 - Provide that “charges” for services rendered by a person who violate the above solicitation provisions are noncompensable by the insurer or insured.
 - Amend the Offense Severity Ranking Chart law (s. 921.0024, F.S.) to increase the ranking for the following crimes: soliciting an accident victim with intent to

defraud; unlawfully obtaining or using a confidential crash report; filing a false motor vehicle insurance application; operating an unregistered clinic or filing false registration information; and, organizing, planning, or participating in an intentional motor vehicle collision.

- **Staged Accidents:**

- Provide that it is a second-degree felony to organize, plan, or participate in an intentional motor vehicle collision; require a 2 year minimum mandatory sentence.

- **False Application/Insurance Card:**

- Upgrade the penalty from a first-degree misdemeanor to a third-degree felony for filing a false motor vehicle application.
- Provide that it is a third-degree felony to present a false or fraudulent motor vehicle insurance card.

- **Crash Reports:**

- Require presentation of proper identification to prove identity and entitlement to a confidential vehicle crash report.
- Require persons who obtain confidential vehicle crash reports to sign a sworn statement stating that the information in the report will not be used for any commercial solicitation of an accident victim or knowingly disclosed to a third party for the purpose of solicitation. Violating such a provision is a third-degree felony.

- **Minimum Mandatory Sentences for Insurance Fraud:**

- Require minimum mandatory sentences for insurance fraud which are based on the value of the property subject to the fraud violation. (Note: This recommendation would apply to all types of insurance fraud, not just motor vehicle fraud.)

- **Resources:**

- Increase funding to provide resources to the Division of Insurance Fraud to investigate motor vehicle insurance fraud. Also, provide funding to the Office of the Statewide Prosecutor and the State Attorneys' offices to prosecute motor vehicle insurance fraud. Consider requiring a portion of the auto insurance policy fee collected by agents to be used for this purpose.

Medical Clinics

The Select Committee heard testimony from the Department of Health that health care clinic registration requirements need to be tightened to prevent unscrupulous owners and others connected with such clinics from defrauding the PIP system. Representatives with that agency acknowledge that they primarily regulate professions, not health care entities, and that they lack the requisite expertise, investigative staff, and enforcement authority to adequately regulate clinics. The Select Committee believes that clinic regulation is a critical component in fighting PIP fraud and abuse and that resources be committed to the appropriate oversight agency. We therefore recommend:

- The Legislature require that the Agency for Health Care Administration (AHCA) be provided the financial and personnel resources to regulate health care clinics.
- Tighten overall clinic registration provisions by allowing AHCA to do background investigations and perform on-site unannounced inspections, utilize emergency authority to close clinics for specific violations, and utilize other administrative tools to regulate clinic activity. Require clinics to amend their registrations if material changes occur.
- Mandate that clinics allow full and complete access by AHCA to the premises and to all records.
- Require owners of clinics (no matter what percentage of ownership) and clinic medical directors to have no prior disciplinary, civil, or criminal sanctions imposed within the past 5 years. If such a sanction has been imposed, the individual or entity may not own or serve as medical director of a clinic. If such a sanction is discovered after registration, the clinic must dismiss the offender, face sanctions, and amend its registration.
- Allow entities which are currently exempt under the clinic law to make an expedited filing with AHCA of their exempt status so that insurers and others can easily verify their status on-line.
- Require registration of all mobile health care clinics.
- Make it a third-degree felony for any person who knowingly files a false or misleading clinic registration application or who files false or misleading information pertaining to the registration.

Medical Fee Schedule, Utilization Protocols, Insurer and Provider Issues

Considerable testimony was received regarding abusive and fraudulent practices on the part of those health care providers who over-use or misuse diagnostic tests, inflate charges for such tests or procedures, bill for services never rendered, or make unnecessary referrals to other disciplines. Some of these providers render services or supplies without the proper license or provide services in violation of the applicable law, while others forward statements to the insurer and request payment without providing any medical records. The testimony and evidence indicates that such problems generally do not occur in the hospital setting, but are much more likely to occur in clinics or physician offices.

Testimony was provided that in certain cases, both insurers and providers are improperly and systematically changing codes which apply to the provision of medical services. Furthermore, in some instances, insurance companies improperly request physicians preparing independent medical examination (IMEs) reports to change or modify the report.

In order to address these concerns, the Select Committee recommends:

- Establish a medical fee schedule for all treatments under PIP and tie it to a specific percentage of the Medicare fee schedule. Provide authority for AHCA to establish a schedule for procedures not specifically addressed in the Medicare fee schedule. Exempt hospitals from the fee schedule.
- Authorize AHCA to establish a list of diagnostic tests that are specifically deemed to be not medically necessary.
- Clarify that insurers and their insureds are not required to pay any statement or bill that does not meet the specified medical fee schedule, is fraudulent, not medically necessary, or does not meet the requirements applicable to properly completed billing statements.
- Authorize AHCA to establish PIP utilization protocols for medical treatments in conjunction with the appropriate medical boards.
- Clarify that insurers may not improperly downcode or bundle billing of codes (services) with the intent to deny reimbursement otherwise due. Also, clarify that providers may not improperly upcode or unbundle the billing of services.
- Require insurers upon receipt of a first billing by any provider to verify and keep on record the name of all providers and their license or clinic registration numbers.

- Prohibit insurers from requiring physicians to change IME reports.
- Mandate that insurers rotate, on a yearly basis, physicians who prepare IME reports and that physicians maintain, for at least 3 years, copies of all examination reports as medical records and the records of all payments for such exams and reports.
- Clarify that Medicare Part B reimbursement is the schedule applicable to “participating” physicians.
- Clarify that the MRI fee schedule first went into effect for services and treatment on or after June 19, 2001, the effective date of the legislation (ch. 2001-271, L.O.F.).
- Clarify that the current MRI fee schedules be adjusted annually by the appropriate index.
- Clarify that if medical treatment is rendered out of state, the reimbursement amount is set for the area where the insured resides.

Mediation, Attorney’s Fees, Demand Letter

The Select Committee heard testimony from insurers that the cumulative effect of statutory and case law provisions encourage lawsuits and coerce unreasonably high settlements and attorney’s fees. These provisions include the one-way attorney’s fees statute which allows only the insured or medical provider to be awarded attorney’s fees if they prevail, but not insurers; Lodestar and contingency risk multipliers which are case law created provisions that can greatly increase plaintiff’s attorney’s fees; civil remedy and punitive damage provisions which may be utilized against insurers; plus payment of interest and costs. The insurance companies assert that many PIP reductions and denials (pertaining to payments for medical services) are litigated, even though the amount in controversy is relatively small, because of the potential for large awards for attorney’s fees.

Representatives of the plaintiff’s bar testified that insureds need attorney representation, based on contingency fee arrangements, in order to “level the playing field” between the insured and the insurance company and that without these provisions, noted above, an insured could not obtain representation to stand up to unscrupulous insurers. They also point out that Lodestar and multipliers are used in other civil cases and that a court is guided by objective standards in determining the appropriate amount of attorney’s fees.

In an effort to ameliorate the litigious nature of the PIP insurance system, the Select Committee recommends that:

- Parties utilize the current voluntary insurance mediation law (s. 627.745, F.S.) which applies to PIP claims and allows either party the option to choose mediation. The option

to use mediation would affect the application of attorney's fees and costs in the following manner:

- An insurer *would be liable* for attorney's fees and other extraordinary remedies if it declines to participate in mediation or declines to pay the recommended (mediated) amount. The insurer is *not liable* for attorney's fees and other extraordinary damages if the claimant declines to mediate, or if the insurer pays the amount demanded or mediator's recommended amount, plus mediator's fee, and interest.
- If mediation is successful, the neutral mediator selected by the Department of Financial Services or the Office of Insurance Regulation, would issue a written report recommending the amount, if any, payable by the insurer.
- Expand the provisions of the current presuit demand letter (s. 627.736(11), F.S.) to be applicable to all PIP disputes and increase the time for insurers to respond to the letter from 7 business days to 15 calendar days.
- Limit the use of contingency risk multipliers to cases of great public importance, e.g., where there is a change in the law.
- Clarify that the offer of judgment provision (s. 768.79, F.S.) applies to PIP cases.
- Define the term "permanent injury" as it relates to the verbal threshold for non-economic damages (pain and suffering), in order to limit claims for pain and suffering to serious or significant permanent injuries.
- Broaden the current provision allowing insurers to bring a civil cause of action (s. 627.736(12), F.S.) by allowing both insurers and insureds to sue a person who was engaged in insurance fraud, patient brokering, or kickbacks associated with PIP claims.
- Clarify that notwithstanding their payments, insurers and their insureds are not precluded from maintaining a civil action to recover payments for services later determined to have violated the PIP statute, or were unlawfully rendered.
- Specify that, for the demand letter, the Chief Financial Officer is the agent for service of process if the insurer does not file an address for demand letters.

PIP Benefits

The Select Committee heard testimony that the \$10,000 PIP coverage benefit has not kept up with inflation and is worth \$3,730 in today's dollars based on the Consumer Price Index. The Select Committee has concerns that increasing the \$10,000 limit will increase the cost of PIP coverage unless it is offset by other factors. To address this issue, the Select Committee recommends:

- That the Legislature consider increasing the \$10,000 PIP benefit in a future legislative session, if the increase in PIP premiums is offset by the reduction in PIP rates resulting from the enactment of the recommendations of this report.

Thank you for recognizing the importance of these issues and for providing a forum for interested parties to participate.

Sincerely,

Senator JD Alexander
Chairman